



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

Memorial Compounding Pharmacy

**Respondent Name**

XL Specialty Insurance Company

**MFDR Tracking Number**

M4-16-0605-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

November 6, 2015

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "I am seeking reconsideration on this bill that has been denied stating preauthorization is required. These medications do not require preauthorization and are to be retrospectively reviewed."

**Amount in Dispute:** \$1360.50

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "For three of the dates of service in dispute, 4/30/14, 9/30/14, and 10/29/14, the dispute was not timely filed within one year of the date of service..."

The date of service 4/14/15 was denied in part due to an extent of injury dispute. Requestor utilized ICD-9 code 959.9 which is not an accepted condition listed on the PLN-11 filed on 8/28/14. Therefore, the denial of the services should be upheld as the condition for which the medication was prescribed is not an accepted compensable diagnosis."

**Response Submitted by:** Downs-Stanford, P.C.

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 30, 2014; October 29, 2014; April 14, 2015; April 30, 2015	Prescription Medication (Compound)	\$1360.50	\$489.96

### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.305 sets out the general procedures for resolving medical disputes.

2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §141.1 defines the procedures for requesting a Benefit Review Conference.
4. 28 Texas Administrative Code §134.500 defines terms used for pharmaceutical benefits.
5. 28 Texas Administrative Code §134.503 sets out the guidelines for billing and reimbursing pharmaceutical services.
6. Texas Labor Code §410 sets out the requirements for adjudication of disputes.
7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:  
For date of service 4/14/15:
  - 219 – Based on extent of injury
  - 50 – These are non-covered services because this is not deemed a ‘medical necessity’ by the payer.
  - PI – These are adjustments initiated by the payer, for such reasons as billing errors or services that are considered not reasonable or necessary.
  - OA – The amount adjusted is due to bundling or unbundling of services.
  - 193 – Original payment decision is being maintained. This claim was processed properly the first time.For date of service 4/30/15:
  - 50 – These are non-covered services because this is not deemed a ‘medical necessity’ by the payer.
  - PI – These are adjustments initiated by the payer, for such reasons as billing errors or services that are considered not reasonable or necessary.
  - OA – The amount adjusted is due to bundling or unbundling of services.
  - 193 – Original payment decision is being maintained. This claim was processed properly the first time.

### **Issues**

1. Did the requestor waive the right to medical fee dispute resolution for dates of service September 30, 2014 and October 29, 2014?
2. What is the correct remedy for the dispute for date of service April 14, 2015?
3. Did the insurance carrier appropriately raise medical necessity for this dispute for date of service April 30, 2015?
4. Are the disputed charges for date of service April 30, 2015 subject to bundling rules?
5. What is the total reimbursement for the disputed service?
6. Is the requestor entitled to additional reimbursement?

### **Findings**

1. 28 Texas Administrative Code §133.307(c)(1) states:

Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.

(A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

The dates of the service in dispute include September 30, 2014 and October 29, 2014. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on November 6, 2015. This date is later than one year after these disputed dates of service. Review of the submitted documentation finds that these disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file the dispute for these dates of service with the Division's MFDR Section. Consequently, the requestor has waived the right to medical fee dispute resolution for dates of service September 30, 2014 and October 29, 2014.

2. This medical fee dispute contains unresolved issues of extent of injury for date of service April 14, 2015. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) responses during the medical billing process.

**Dispute resolution sequence:** 28 Texas Administrative Code §133.305(b) requires that extent of injury disputes be resolved prior to the submission of a medical fee dispute for the same services. 28 Texas

Administrative Code §133.307(f)(3)(C) provides for dismissal of a medical fee dispute if the request for the medical fee dispute contains an unresolved extent of injury dispute for the claim. 28 Texas Administrative Code §133.307(c)(2)(K) provides that a request for a medical fee dispute must contain a copy of each EOB related to the dispute.

**Extent of Injury dispute process:** The Division hereby notifies the requestor that the appropriate process to resolve the issue of extent of injury for date of service April 14, 2015, including disputes or disagreements among the parties over whether the medical services in dispute were related to the compensable injury, may be found in Chapter 410 of the Texas Labor Code, and 28 Texas Administrative Code §141.1. As a courtesy to the requestor, instructions on how to file for resolution of the extent of injury issue are attached.

Because an unresolved extent of injury issue exists, date of service April 14, 2015 will not be considered in this dispute.

3. The insurance carrier denied disputed charges for date of service April 30, 2015, in part with claim adjustment reason codes 50 – “THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT DEEMED A ‘MEDICAL NECESSITY’ BY THE PAYER,” and PI – “These are adjustments initiated by the payer, for such reasons as billing errors or services that are considered not reasonable or necessary.”

28 Texas Administrative Code §137.100(e) states, “An insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonably required. The assertion must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017.”

Retrospective utilization review is defined in 28 Texas Administrative Code §19.2003(b)(31) as, “A form of utilization review for health care services that have been provided to an injured employee. Retrospective utilization review does not include review of services for which prospective or concurrent utilization reviews were previously conducted or should have been previously conducted.”

In addition, 28 Texas Administrative Code §133.240(q) states, in relevant part, “When denying payment due to an adverse determination under this section, the insurance carrier shall comply with the requirements of §19.2009 of this title ... Additionally, in any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of §19.2010 of this title ..., including the requirement that prior to issuance of an adverse determination the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor ...”

Submitted documentation does not support that the insurance carrier followed the appropriate procedures for a retrospective review denial of the disputed services outlined in §19.2003(b)(31) or §133.240(q). Therefore, the insurance carrier did not appropriately raise medical necessity for this dispute.

4. The insurance carrier denied disputed charges for date of service April 30, 2015, in part with claim adjustment reason code OA – “The amount adjusted is due to bundling or unbundling of services.” Review of the applicable fee rules for pharmacy services does not find that the charges in dispute for this date of service are subject to bundling rules. The insurance carrier’s denial for this reason is not supported. Therefore, the disputed charges for this date of service will be reviewed in accordance with applicable rules and fee guidelines.
5. The total reimbursement for the disputed services is established by the AWP formula pursuant to 28 Texas Administrative Code §134.503 (c), which states, in relevant part:
  - (c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:
    - (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:
      - (A) Generic drugs:  $((\text{AWP per unit}) \times (\text{number of units}) \times 1.25) + \$4.00$  dispensing fee per prescription = reimbursement amount...

(2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:

(A) health care provider

The requestor is seeking reimbursement for a compound of the generic drugs Baclofen, NDC 38779038809; Amantadine HCl, NDC 38779041105; Gabapentin, NDC 38779246109; Amitriptyline HCl, NDC 38779018904; and Bupivacaine HCl, NDC 38779052405. The disputed medication was dispensed on April 30, 2015. The reimbursement is calculated as follows:

Date of Service	Prescription Drug	Calculation per §134.503 (c)(1)	§134.503 (c)(2)	Lesser of §134.503 (c)(1) & (2)	Carrier Paid	Balance Due
4/30/15	Baclofen	$(35.63000 \times 5.4 \times 1.25) + \$4.00 = \$244.50$	\$184.68	\$184.68	\$0.00	\$184.68
4/30/15	Amantadine HCl	$(24.22500 \times 3.0 \times 1.25) + \$4.00 = \$94.84$	\$38.46	\$38.46	\$0.00	\$38.46
4/30/15	Gabapentin	$(59.85000 \times 3.6 \times 1.25) + \$4.00 = \$273.33$	\$188.10	\$188.10	\$0.00	\$188.10
4/30/15	Amitriptyline HCl	$(18.24000 \times 1.8 \times 1.25) + \$4.00 = \$45.04$	\$30.70	\$30.70	\$0.00	\$30.70
4/30/15	Bupivacaine HCl	$(45.60000 \times 1.2 \times 1.25) + \$4.00 = \$72.40$	\$48.02	\$48.02	\$0.00	\$48.02

6. The total reimbursement amount for the disputed service is \$489.96. The insurance carrier paid \$0.00. An additional reimbursement of \$489.96 is recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$489.96.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$489.96 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### **Authorized Signature**

_____ Signature	_____ Laurie Garnes Medical Fee Dispute Resolution Officer	_____ December 4, 2015 Date
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### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**

## HOW TO FILE FOR RESOLUTION OF AN EXTENT OF INJURY ISSUE

A health care provider that chooses to pursue resolution of the extent of injury issue should submit the following **to the field office handling the claim:**

- Completed DWC Form-045 *Request to Schedule a BRC*, including:
  - Section III. PARTY REQUESTING
    - ✓ 10. Select Sub-claimant
  - Section IV. ISSUE(S) TO BE MEDIATED
    - ✓ 17. Select “extent of the compensable injury”
    - ✓ 18. State **“Do any or all of the services provided in the attached medical bill(s) extend or relate to the compensable injury of (injured employee’s name )?”**
- Attach to the DWC- Form045:
  - ✓ a copy of the dismissal and this page;
  - ✓ medical bills for date of service: April 14, 2015;
  - ✓ the notice to the injured employee required by 28 Texas Administrative Code §140.6 (c)(2)(D), *Subclaimant Status*; and
  - ✓ any other information/documentation required in the form instructions.

**THIS IS THE QUESTION  
THAT MUST BE  
ANSWERED**

### Health Care Provider Frequently Asked Questions (FAQ)

Q: Who can I call with questions about this dismissal?

A: You may contact the dispute resolution officer that issued the notice or MFDR via email at [MDRInquiry@tdi.texas.gov](mailto:MDRInquiry@tdi.texas.gov). Please include the MFDR tracking number in your email.

Q: Why was my dispute dismissed?

A: The Compensability, Extent-of-Injury, Liability issue/denial for the date(s) of service in dispute must be resolved prior to the determination of fees. MFDR cannot take action on the service date(s) at this time; for that reason, the medical fee dispute was dismissed.

Q: What are my options?

A: The healthcare provider has the option to pursue resolution of the, Extent-of-Injury, Compensability and/or Liability issue as instructed above; withdraw because it does not intend to pursue the, Extent-of-Injury, Compensability and/or Liability issue; or provide documents to support that a final decision on, Extent-of-Injury, Compensability and/or Liability was made for the date(s) of service in dispute.

Q: How can I get a copy of a DWC Form-045?

A: Go to [www.tdi.texas.gov/wc/forms](http://www.tdi.texas.gov/wc/forms) or call CompConnection at 1-800-372-7713 option 3 if you require a copy by fax or mail.

Q: Who can I call with questions about resolution of the extent issue or filing the DWC Form-045 Request to Schedule a BRC?

A: Contact your local field office - <http://www.tdi.texas.gov/wc/dwccontacts.html>

Q: Can I submit a new dispute or DWC Form-060 after resolution of the, Extent-of-Injury, Compensability and/or Liability issue?

A: Yes. The medical fee dispute may be submitted for review as a new dispute. The provider should include any new EOBs, and the final decision on, Extent-of-Injury, Compensability and/or Liability for date(s) of service in dispute.

Q: Will my new medical fee dispute or DWC Form-060 be denied if it is filed later than one year?

A: If the healthcare provider submits documents to support that a final decision on, Extent-of-Injury, Compensability and/or Liability was made for the date(s) of service in dispute, the one-year filing deadline does not apply. The provider is responsible for filing the dispute not later than 60-days after it receives a final decision on, Extent-of-Injury, Compensability and/or Liability for the date(s) of service in dispute.